



**This is a guide only and does not
replace clinical judgment**

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Diabetic Foot Ulcers

Information for health professionals



Diabetic Foot Ulcers

Assessment

- Assessment should be undertaken by trained health practitioners
- Measurement of Ankle Brachial Pressure Index (ABPI) is essential. An ABPI of <0.9 indicates arterial disease and an ABPI >1.2 requires further investigation
- Neuropathy and loss of sensation can be determined by monofilament testing in combination with clinical assessment
- Assess risk factors (neuropathy, PAD, foot deformity) and classify foot ulcer risk as:
 - low: no risk factors or history of foot ulcer/amputation;
 - intermediate: one risk factor and no history of foot ulcer/amputation; or
 - high: 2 or more risk factors and/or history of foot ulcer/amputation



Diabetic foot ulcers are usually on the sole of the foot or over pressure points. They are frequently surrounded by dry, thin and/or calloused skin.

- Refer to a specialist when there is:
 - uncertainty in diagnosis
 - a low or high ABPI
 - need for revascularisation
 - no progress in epithelialisation within 2 weeks of debridement and commencing off-loading
 - signs of infection or inflammation
 - the wound can be probed to bone
 - wound deterioration or new ulceration
- Regularly document wound characteristics and progress in healing

Management

- Involve a multi-disciplinary team with GP, nurse, podiatrist, orthotist, endocrinologist. Consider remote expert advice with digital imaging for people living in remote areas
- Offloading of pressure points is necessary e.g.
 - crutches, walkers or wheelchairs
 - custom shoes, modifications or inserts
 - custom relief orthotic walkers
 - forefoot and heel relief shoes
 - total contact casts
- Facilitate oxygenation of wound environment - avoid dehydration, smoking, cold, stress, pain
- Optimise glucose control
- Irrigate ulcer with a neutral, non-toxic solution, and cleanse with minimal trauma

- Remove necrotic and devitalised tissue, unless revascularisation is necessary
- Debridement should only be undertaken by trained health professionals
- Maintain a moist environment, except when dry gangrene or eschar is present
- Topical antimicrobial dressings may benefit chronically or heavily colonised wounds
- Re-evaluate treatment if the ulcer size fails to reduce by 40% after 4 weeks of therapy
- Additional therapy may help clients, e.g.:
 - topical negative pressure therapy
 - cultured skin equivalents
 - hyperbaric oxygen therapy

Prevention

- All individuals at risk (i.e. PAD, neuropathy, callus, foot deformity, previous ulceration, amputation) need protective footwear
- Ensure correct foot care is practised, including daily inspection of feet
- A trained health professional should undertake a foot examination:
 - annually in those at low risk
 - 3-6 monthly in those at intermediate or high risk
- Optimise glucose control
- Discourage individuals from smoking
- Encourage maintenance of a healthy weight
- Provide a foot protection program for those at intermediate or high risk for foot ulceration